The Bulletin
OF THE
South Indian Medical Union.

Vol. III. | JULY 1931. | No. 7.

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Altruism in the Profession.

IT is human nature for men of proficiency to seek positions commanding the highest remuneration for their services. But in our medical profession, the needs of the people should be above personal considerations. Instances of self-sacrificing service in our midst are by no means uncommon and those of our colleagues who are to take any significant share in the medical and public health reconstruction of this country, should set for themselves an altruistic motive as their guiding principle. It is then and only then, that we can look forward with greater promise to the development of our profession. At no time of China's history is altruism more needed than during this reconstructive period, and in no profession is it more urgent than in medicine—the noblest of all.

National Medical Journal of China.

How true is this of India !!

BULLETIN

OF THE

SOUTH INDIAN MEDICAL UNION.

JULY 1931.

We regret to record the deaths of

Dr. R. Viswanathan, Coimbatore

and

Dr. R. Hariharan, Kalakad.

Drs. Viswanathan and Hariharan were strong supporters of the Union and have been doing active work in organizing the Independent Medical Profession in their respective towns. We offer their bereaved families our sincere sympathy.

GENERAL NOTES.

All is well that ends well. We hear that the unhappy state of affairs that we had reported as existing at Karur have been removed and cordial relations have been re-established between the service and the Independent Medical Profession. These strained relations generally repercuss on the medical profession as a whole and will lead to a lowering of its prestige in the eyes of the General Public. We offer our commendations to Mr. P. Seshadri, I. C. S., Sub-divisional Officer at Karur, to whose efforts, we understand, this happy result has been mainly due.

* * *

The annual day of the Royapuram Medical Students' Union was held this month. Hon. Diwan Bahadur Muniswami Naidu, Minister for Health, very aptly presided. He sympathised with the aspirations of the students and agreed with the necessity for improvement of medical education and extension of the course to five years in the Schools, but pleaded the financial stringency as standing in the way of an immediate realisation of his and their wish. We wonder whether the possible avenues of retrenchment and reappropriation of funds have been seriously considered. If it is done we are sure that financial stringency would not be *the* barrier for improving the education and consequently the status of the L.M.Ps.

That cinderalla of the medical profession, the L.M.P., is hardly given any occasion of rejoicement. He has his diplomas and prizes sent to him by post. He has no ceremonial befitting such an occasion, and no one will dispute that ceremonials have a great value in creating impressions. We are glad that a beginning has been made. At the last school day the diplomas and prizes were distributed. We congratulate the Superintendent, Major V. Mahadevan, M.R.C.P., F.R.C S., in trying to create an *academic* orientation to such events and hope that before long, the school students would have a regular and impressive convocation to suit the solemness and dignity of the occasion of their entry into the medical profession.

* * *

The recent transfer of Dr. Satakopan from Royapuram Hospital and the appointment of Dr. K. C. Paul, M.D., to his place has had a curious sequel. The number of beds in the charge of the honorary physician has been reduced from 37 to 10 and a reallocation of the beds have been made. We were under the impression that a transfer involved only a change of person and not change of the number or location of the beds in his charge.

False Oracles.

No good cause has ever lacked fierce opponents, and nothing of permanence has ever been achieved without determined effort against detractors, unctuous critics and unrighteous combinations. We are not therefore surprised at the critics who seem to newly arise or the increasing or everchanging arguments that are advanced against the continuance, not to speak of the extension of the Honorary scheme. But there are some among the profession who get discouraged by every unpleasant episode or the irresponsible talk of those who are known opponents of the scheme. We shall here attempt to trace the progress of the opposition, that our young men may be enabled to assess its value and its proper place in the scheme of things.

When the Honorary scheme was in the air, the critics conceded that it would be useful, but gravely doubted whether capable men with the necessary equipment and public spirit would be available here. When the men came forward, our critics were concerned about the maintenance of *discipline*—blessed word! It was contended that the presence of honorary medical officers would interfere with the smooth working of the institution. In spite of the honoraries, the institutions kept running as usual Now the patients came to the rescue of the critics. Would not the patients object to being treated by these supernumerary men? They did not seem to fret, in fact, these patients appeared to like the new set of men much better. It was put forth that the presence of honorary officers was a strain on the nursing staff, and then on the medical staff! None of these grave objections materialised and there was disappointment in certain quarters. But human ingenuity is resourceful and fresh arguments were still available. Were the men in service to treat the honorary officers as equals and superiors? Up to this stage, criticism was apparently a pastime with them. In spite of adverse criticism and hindrances, the honorary scheme remained and slowly expanded. From now onwards, a certain amount of anxiety is traceble in their criticism. This is well reflected in their query "whether the honorary men could ever replace paid men in any department of medical relief and education". Lest it should be answered in the affirmative, our critics themselves hastened with the answer that there was room for unlimited numbers of both of them, but in different spheres. It were well for these critics if things had stopped

there. But unfortunately for them it is rumoured that the government and its medical adviser are engaged in the serious task of devising plans for extension of medical relief, decreasing finances staring them in the face and that one of the methods proposed is that of replacement of the paid staff by honorary workers in suitable places. The imaginary or real fear of some of the former that they may not get or retain a few coveted posts seems to have unsettled them completely. While the suddenness of the rumours has surprised them into silence, they have not been slow in prompting a foolish few of them to put up a brave fight for a wrong cause. The brave generally blunder. It is seriously questioned whether the mere practitioners have any claims to be associated with institutions owned and maintained by the State. A school boy might ask, "Pray, what is the State and whose be it?" We shall merely mention that these are questions for the State to solve and not for its servants to propound. These officers in the enthusiasm for their assistants ignore common sense and dictate for the benefit of an ignorant world that their assistants are incomparable and irreplaceable for all time. We pity their professional efficiency and the lack of even elementary forethought. Has it never struck these officers that they cannot keep their assistants for ever with them and that they so easily survive the frequent transfers of their devoted assistants. We wonder if it be the same officer who in the recent District Medical Officers' Conference raised the bogey of disintegration of services as a result of the 'subversive' principle of Honorary medical relief!

We had hoped that medical men all over the province would understand the spirit and purpose behind the scheme of Honorary medical relief. But we are pained to observe that there are still among us, many who are ignorant of the philosophy of this scheme. We shall again make an attempt to explain the essence of this scheme for their benefit.

Young men fresh from their college or school are keenly interested in questions of post-graduate medical education and they desire to utilise the many idle hours of the early years of practice in equipping themselves better for the career ahead. They have heard from their teachers that the best thing for a recently qualified medical man is to work in a hospital, preferably a teaching hospital, for a few years. It is now also common for the lay public to insist on a young graduate having some practical experience in a hospital after graduation. Further while at college or school, these young men have listened to appeals, moving and flattering, that the medical profession being easily the noblest of all, its votaries should place service to ailing humanity above every other thing, and that they should ever welcome opportunities of service to the surrounding population. Their professional mentors and the political leaders, whenever they address a group of medical men or students remind them of the vastness of the field and the want of resources, and appeal to them to leave the beaten track and to carry the torch of health and sanitation to the rural areas.

In the midst of little work and lengthening weariness, the young medical man recalls to his mind the high precepts of his professors; and attracted by the vision of glory that is promised to await him at the end of his work for the sick poor, he responds to the moving appeals for workers. It ill-accords with their former teaching for these teachers to turn round and say that honorary work is a myth and that the honorary scheme a retrograde step.

Paid Medical Service.

In a previous issue of the Bulletin, while discussing the problem of medical relief in Madras, we stated that in most countries, the *independent* profession took the lead in ministering to the needs of the sick population. We have since received from some of our readers letters drawing our attention to the fact that there are suggestions in England to organise a *state* General Medical Service. They desire to know whether we are justified in advising the introduction in this country of ideas and measures which are being discarded in England. The local Service Organ even expresses a certain pride and delight that England is just thinking of measures, which have long been the characteristic of this country. The cynic might think of the famous "fur coat" argument. But the earnestness of our readers demands a serious attempt on our part to argue our case. None so, since we find a regrettable self-complacency in quarters where one would ordinarily expect a better appreciation of the varying needs of different countries.

We urgently require for our country a large number of well educated medical men who could efficiently help the increasing number of the sick population, specially in the rural areas which are at present, almost totally neglected. None of our readers would deny this. How are we going to secure this large number of medical men? If the men are to be trained up to a reasonable level of efficiency, a great deal of money would be required. Admittedly the money is not available, and still less to engage them all in a paid service. As there is no prospect of the country suddenly coming into luck to enable it to have the luxury of a fully paid general medical service, it is profitless to compare it with what obtains elsewhere.

When we come to see the methods adopted by other countries, nowhere do we see anything like the paid medical service in this country. It is true that we hear of suggestions for a general medical service in England. But this new leaning is not from a lack of appreciation of the merits of the independent profession. It is primarily due to the inadequacy of the non-government voluntary hospitals to accommodate more of the lower middle and labour classes of the population. As socialism advances in a country we are certain to hear more and more of the demand for a state-paid medical service.

This idea of a state-paid medical service has emanated from the politicians and not from the profession. In fact, the profession in England is generally opposed to this suggestion. It values its independence too highly to be misled into a career of ease loving red-tape. We do not deny that there are some in the profession, a few of them even eminent, who are strong supporters of this new idea. They do so because they are not satisfied with the present state-subsidised panel service. They feel that the patients go without the necessary advice and help of the specialists and consultants. They feel that the panel practitioners have to work under irksome restrictions and that they are not able to give their patients the benefit of a senior consultation when they feel the necessity. To obviate these defects of the Health Insurance Panels, they ask for a state-paid service whereby they hope to give the panel practitioners the benefit of consultation with seniors and specialists at state expense. This has absolutely no likeness to the state-paid service which obtains here. It would be a service whose members would be expected to render free medical aid to the population in return for a fixed fee paid by the Government. It would not be a service whose members could

have the benefit of a generous pay from the State as well as unlimited fees from private practice. It would be a full-time service with fixed pay or a part-time work with proportionate remuneration. It would not certainly be a part-time service with more than full-time emoluments as is common in this country.

The general practitioner or the family physician has been the back bone of the profession in all countries. Though the consultants and the present day specialists are generally the most eminent in the profession and their advice and guidance are freely availed of by the practitioner and the public, it is the family physician who is intimate with his patients. He alone possesses their confidence. He gains this position by dint of his alertness, hard work, ability and sympathy. He realises from the beginning that his career is cast with the well-being of his patients, and he strives to maintain it. He gains his living, achieves a status and succeeds in keeping his soul. But let him be yoked in *service* and assured of a living he will do his allotted task, he may even bring his conscience to bear on it; but his thoughts are set not in front of him among his patients, but behind him at the little coteril of officials who have the ordering of his career. And often is a soul thus lost!

Much of the original work in medicine has been accomplished by men who worked hard among their patients unfettered by official codes and regulations. On the other hand, the original contributions have been very few from men who have chosen a career in one of the services with the security of pay and pension. There is a vast field for research in our country. There are many mysteries of disease to be unravelled. We require men with energy, workers with ideas and initiative who would be free to follow their investigations without the hindrance of official documents and instructions. We could obtain these men only by bringing up a virile independent profession whose members should be encouraged to get on the staff of the various state hospitals and schools in increasing numbers.

Every one talks of the increasing ravages of tuberculosis, every one pretends to be overcome by the appalling mortality from malaria and fervent effects ending with long winded perorations are made from public platforms for an army of trained workers, medical men, and a net work of special institutes and hospitals for these and similar diseases. But these conditions cannot come in as long as *nearly 50 per cent of the expenditure of the medical department goes towards the salaries of the medical staff*. They cannot wish well of the country who, in these circumstances, plead for enlarging the system of a paid medical service. It was a happy inspiration of the Government that they introduced the honorary and the rural schemes. During the seven years of its existence, wind-tossed and weather beaten, and in spite of the brackish waters the saplings promise to take root and grow. In these days of budget deficits, if the available money is to be frittered away in payments as salaries and allowances it has to be at the expense of essential medical necessities to the suffering public. As a first measure of retrenchment we would exhort the Government to expand fully the honorary system, not as supernumararies, but in place of the paid Service. It is only then, that medical relief could be extended and an avoidable burden lifted from the shoulders of the tax-payer.

Honorary Committee.

THE Local Government have appointed a Committee to examine the working of the system of employing

honorary physicians and surgeons in State hospitals. This Committee, which will soon begin its work, has a difficult problem to study and find a solution for. The Committee must never lose sight of the object with which the system was introduced. It was introduced, for one thing, as a measure of economy. There is no reason why, when qualified honorary medical officers are available, a large costly paid agency should be employed. In the next place, it was considered desirable that the members of the independent medical profession should be allowed opportunities of keeping themselves in touch with up-to-date hospital practice, contributing, in return, their services for a limited period free. It cannot be said that the system, as it obtains to-day, has succeeded in attaining these objects. The introduction of the honorary system has not resulted in the reduction of the hospital staff by a single paid medical officer in the hospitals. From the economy point of view, therefore, the system cannot be said to have been much of a success. The system has failed no less in regard to the other object, namely, that of giving an opportunity to the members of the independent medical profession to keep themselves in touch with the latest developments in hospital practice. The honorary officer, it is notorious, has not felt his position an easy one. The general feeling among these officers is that they are treated as inferiors, that they are not allowed opportunities to do responsible work and that obstacles of one sort or another are placed on their path. It will, of course, be one of the most important functions of the Committee to investigate these charges and similar complaints which the members of the medical services have made against the inconveniences which result to them because of the system. It is also necessary to give a chance to as many independent medical men as possible, say, by a system of rotation. The paid medical officers seem to feel that the honoraries constitute a misfit in the present system and that if the system is to be of use, it should be considerably modified. It is just possible that some honorary officers take their job too lightly and that they consider it, not as a serious responsibility, but as a sort of honour to them. This attitude is to be deprecated. In our view, if the system is to succeed, there should be absolutely no difference whatsoever between an honorary officer and a stipendiary one so far as hospital discipline, status, access to appliances, privileges and so on are concerned. We do not see why members of the medical service should not treat as their equals men with identical qualifications and capable of doing similar work. And as for the qualifications of honorary officers, we think the idea is to enlist as such the services only of duly qualified men. The public do not like a cheap agency if cheapness can be secured only at the cost of efficiency. And it cannot be said that men with high qualifications are not available. It must be one of the duties of the Committee to lay down proper qualifications for practitioners to be entitled to be appointed honorary officers. If these officers happen to be men with inferior qualifications, it is but human if service-men look upon them as inferiors. If, on the other hand, men with qualifications equal to those of the paid officers are chosen, there will be less difficulty in harmonious, disciplined team work between the paid and honorary officers. In any case, the Committee must recognise that if the system is to succeed "similar work and equal treatment" for both the categories of medical officers, paid and honorary, ought to be accepted as the fundamental basis of hospital organisation.

THR HINDU, *July 15th, 1931.*

ASSOCIATION NOTES.

Indian Medical Association.

A general meeting of the Bengal Branch of the Indian Medical Association was held at 7-30 p.m. on the 29th May 1931, at 36, Wellington Street, Calcutta.

Members Present:

Dr. Sibamay Mondal.
" Rajat Chandra Sen.
" Maniklal Das.
" Bhupati Ranjan Sarkar.
" Amiya Madhab Mullick.
" Kalikinkar Sen Gupta.
" Hemendra Narayan Ray.
" Monmohun Kumar.
" K. S. Ray.
" A. N. Ghosh.
" Harihar Ganguli.
" Anil Kumar Chakraverty.
" Sushil Kumar Sen.
" Sushir Kumar Bose.
" A. C. Ukil.
" Kristo Ch. Chakraverti.
" S. C. Sen Gupta.
" K. B. Mukherjee.
" Amulyadhon Mukherjee.
" B. K. Roy.
" B. K. Ghosh.
" D. P. Ghosh.
" Charu Chandra Banerjee.

Dr. Amiya Madhab Mullick was voted to the chair.

1. Before the regular proceedings commenced the Chairman reported the untimely death of Dr. Debi Prosanna Basu, which melancholy event took place on the 24th May last and moved the following resolution:—

This meeting records its deep sense of sorrow at the sad and untimely death of Dr Debi Prosanna Basu, M.B., who was one of the foundation members of the Indian Medical Association and the Assistant Secretary of the All-India Medical Conference and as such rendered valuable services to the cause of the Association.

Carried unanimously, all standing.

2. The proceedings of the last meeting were read and confirmed.

3. Resolved that the Executive Committee be formed of (i) 15 members from Calcutta, (ii) 5 members residing in mofussil and (iii) 1 member from each branch as it is formed.

The arrangement is to operate till the next election.

4. Resolved that Sir Nilratan Sircar be elected President.

Carried unanimously.

5. As eight names were proposed for the Vice-Presidentships, voting was done by ballot and the following were declared elected as receiving the highest number of votes:—

Dr. B. C. Roy (21 votes).
" N. N. Basu (18 votes).
" Mrigendra Lal Mittra (18 votes).
" Sundari Mohan Das (16 votes).
Mahamahopadhyaya Kaviraj Gananath Sen (14 votes).

6. Resolved that Dr. Rajat Chandra Sen be elected Treasurer.

Carried unanimously.

7. Resolved that Dr. K. S. Ray be elected Secretary.

Carried unanimously.

8. Resolved that Dr. Anil Kumar Chakraverty and Dr. Sushil Kumar Sen be elected Joint Assistant Secretaries.

Carried unanimously.

9. Resolved that the following 15 members residing in Calcutta be elected to the Executive Committee:—

(1) Dr. S. C. Sen Gupta.
(2) " J. N. Bose.

(3) Dr. D. P. Ghosh.
(4) „ Harihar Ganguli.
(5) „ H. N. Roy.
(6) „ A. C. Ukil.
(7) „ Charu Ch. Banerjee.
(8) „ Hemendra N. Ghosh.
(9) „ K. C. Chakraverti, L M.F.
(10) „ S. K. Basu (Kidderpore).
(11) „ Amiya Madhab Mullick.
(12) „ Aghore Nath Ghosh.
(13) „ K. B. Mukherjee.
(14) „ Bhupati R. Sarkar, L.M.F.
(15) „ N. Chandra.

Carried unanimously.

10. Resolved that the following five members residing in the mofussil be elected to the Executive Committee:—

(1) Dr. Kali Kinkar Sen Gupta (Burdwan).
(2) „ Satya Ranjan Ghosh (Faridpur).
(3) „ J. R. Dhar (Jessore).
(4) „ Satish Chandra Gupta (Jalpaiguri).
(5) „ B. K. Ghosh (24 Parganas).

Carried unanimously.

11. Resolved that the Treasurer be authorised to open a current account with the Central Bank of India, Ltd., Lindsay Street Branch, Calcutta, of the name of the Bengal Branch in the Indian Medical Association.

Resolved further that Dr. K. S. Ray, Secretary, and Dr. Rajat Chandra Sen, Treasurer, be authorised to operate the account.

Carried unanimously.

12. Resolved that Mr. P. C. Nandi, Chartered Accountant, be appointed Auditor of the Branch, his remuneration to be fixed by the Executive Committee.

Carried unanimously.

13. Resolved that five will form a quorum for a meeting of the Executive Committee.

Carried unanimously.

14. Resolved that the Executive Committee be authorised to frame rules and bye-laws of the Association.

Carried unanimously.

Madura Medical Association.

A special meeting of the Madura Medical Association was held on Wednesday, the 3rd June at 5-30 p.m. at the Government Headquarters Hospital, Madura, when the members were "At Home" to Rao Bahadur Dr. A. Lakshmanaswami Mudaliar, President of the Madras Provincial Medical Service Association. There was a large gathering of medical men and women. After the social, Dr. B. Iswarayya, the District Surgeon welcomed the chief guest in a short introductory speech.

Dr. A. Lakshmanaswami Mudaliar delivered an interesting address drawing the attention of the members of the profession to the problems concerning them. He appreciated the cosmopolitan nature of the Madura Medical Association providing a common platform for all types of medical men to meet and discuss all matters. To maintain the dignity of the profession, he said that every medical practitioner must aim high and try to live up to the fullest stature in life. He pleaded for greater unity among the members and explained how a general practitioner and a specialist could co-operate to the best advantage of the practitioners and patients. He emphasised on the necessity of post-graduate education describing how this was carried on in several centres in Europe. He suggested that post-

graduate clinics might be started in all important headquarters hospitals on the same lines as those recently opened in the two presidency hospitals in Madras. He explained how medical associations should standardise their clinical meetings and undertake a type of post-graduate training by organising courses of clinical lectures with the help of specialists. Lastly, he desired that medical men especially those provided with full facilities in large hospitals should undertake clinical research on some suitable subject; for instance research work on "Madura Foot" might be taken by men in Madura itself.

The Chairman while thanking the learned lecturer described the difficulties the medical men in South India had to face in the matter of post-graduate education and clinical research.

Dr. A. N. Menon, the Secretary, proposed the vote of thanks to the lecturer and Chairman and the meeting then terminated.

The Tanuku Taluk Medical Practitioner's Association.

The first anniversary of the Tanuku Taluk Medical Practitioners' Association took place under the auspices of the Tanuku Medical Association at Tanuku in the Hardinge Town Hall, Rao Saheb Dr. T. S. Tirumurti, Acting Principal of the Medical College, Vizagapatam, presided.

Dr. Chittoory Satya Raju read the welcome address.

The President in the course of his reply observed that the most important subject was the All-India Medical Bill, and the constitution of an All-India Medical Council. This would soon be accomplished and would settle all the differences and difficulties now existing.

With a vote of thanks to the President the meeting came to a close after a number of papers was read.

Tanuku Medical Association.

The anniversary of the Tanuku Medical Association took place in Tanuku in Dr. Seshadri Reddy's house, Dr. Tirumurti presided. After light refreshments, the Secretary read his report. Several other doctors also spoke on the occasion.

The following resolutions were passed on the occasion.

1. This conference welcomes the suggestion to establish an All-India Medical Council and strongly recommends that the representation of the independent medical profession in it should be adequate.

2. This conference is of opinion that provision must be made in the register of the proposed All-India Medical Council to include the names of all those medical practitioners whose names now appear in the provincial medical registers instead of the medical graduates only.

3. This conference recommends that the course of study for the L.M.P. Examination be extended from 4 to 5 years and that the preliminary standard for entrance be raised and that the examination for the licentiates be conducted by a statutorily constituted body such as the Bombay or Bengal College of Physicians or Surgeons.

4. This conference is strongly of opinion that the proposed All-India

Medical Council should have full powers of reciprocity.

5. (*a*) This conference welcomes the Government's decision to locate the Medical Research Institute at a University centre and recommends that recruitment to the appointments in this Institute should be made by a specially constituted selection Committee and that no appointments should be reserved for the members of any service.

(*b*) That the members of the independent medical profession be given all possible facilities in the proposed medical research institution to undertake research work.

6. This conference is of opinion that the civil appointments should be entirely dissociated from the military side, that the transfer of I.M.S., I.M.D. officers to civil employment should immediately cease.

7. This conference is of opinion that the competitive examination for recruitment to the Indian Medical Service, which has been held in abeyance for the last several years, should be revived early and that it should be held annually at a convenient centre in India, and that all entrants thereto must possess a qualification registrable in India.

8. This conference is of opinion that there should be no distinction between Indian and Non-Indian officers of I.M.S., with regard to pay, over-seas allowance, passage concession, etc.

9. This conference is of opinion that the Military assistant surgeons, *i.e.*, I.M.D. should be open to all Indians.

10. This conference is of opinion that steps be taken for the proper representation of independent practitioners on the various bodies of the Madras and Andhra Universities and in the Medical Examination Board for Licentiates and the University Boards of these question papers others and examiners.

11. This conference urges the Medical Practitioners to encourage the use of drugs, sera, vaccines, surgical dressings, surgical instruments and other appliances, etc., of Indian manufactures.

12. This conference urges upon the licensing bodies in India to take early steps to make five years the minimum period of study for the medical course.

13. This conference urges upon the Government and local bodies the immediate necessity of allowing private medical practitioners opportunities and facilities for working in all other Hospitals.

14. In view of the fact that extension of medical relief for the public in the rural areas can be secured only by the co-operation of the members of the independent medical profession, this conference is of opinion that the system of honoraries should be made inviting, the existing unsatisfactory conditions being removed.

15. The condition, that the qualification of a person holding the honorary Physician or Surgeon's post should be one registrable in Great Britain should be done away with and the vacancies that occur in the Services owing to retirement or otherwise of the salaried officers should be filled in by honoraries and further recruitment of salaried officers to these appointments should be stopped, except in the case of a few specified posts.

16. This conference thanks the Government for removing one of the disabilities of the members of the ndependent medical profession by

abolishing the system of countersignature on certificates issued by them, but is of opinion that the grace of the concession is lost when the discretion to all for an additional certificate is given to the authority concerned.

17. As where the existing system of medical inspection of the schools in this Presidency is both inadequate and unsatisfactory, this Conference recommends to the Government to induce the managements of Educational Institutions to appoint qualified medical men in its staff, whole-timed or part-timed, to teach Hygiene and Physiology and to conduct medical inspection, preference being given to medical practitioners with experience resident in the locality.

18. This conference requests the Government to encourage rural medical practitioners by increasing the grants for medicines, in the case of dispensaries where the daily average attendance exceeds 30.

19. This conference suggests to the Government that a council consisting of (1) the District Collector, (2) the District Board President, (3) the District Medical Officer, (4) two independent medical practitioners of the district be constituted in each district to administer the scheme of rural medical relief.

20. This conference thanks the Government for recommending a daily allowance of Rs. 5 for rural medical practitioners, deputed on epidemic duty and requests the Government to recommend to the local bodies to sanction an allowance of As. 4 per mile for conveyance charges.

21. This conference, while thanking Dr. M. R. Guruswamy Mudaliar, for his kind offices in securing for the L.M.Ps. admission for the final M.B.B.S. Examination, subject to certain conditions, considers that the obstacles placed before the L.M.Ps. are really insurmountable in as much it requires a further collegiate course in arts and in medicine, for a further period of 4 years, thus entirely disabling at least 95 per cent of the L.M.Ps. from taking advantage of the concessions requests the authorities of the University to remove this hardship, at least when the L.M.P. course is extended for a period of 5 years' standing to appear for the final M.B.B.S. Examinations without insisting on additional courses of study.

22. This conference requests the Government to improve the status of the rural medical practitioners by increasing their subsidy and the supply of drugs and appliances and by permitting them to undertake at least minor medico-legal work.

23. In view of the great demand for nurses and the inability of the Government to meet the same owing to lack of proper women applicants from Andhra desa and in view also of the present great unemployment of educated men in the middle classes this conference requests the Government to try the scheme of training male nurses and entertain them in these hospitals where female nurses are not employed.

24. This conference is of opinion that though the cost of the Kahn and Wasserman tests are considerably reduced even the present rates are prohibitive for the patients in this poor

country, and urges upon the Government the necessity of still further reducing the cost to at least half of the full cost to enable the private practitioners to resort to these diagnostic tests more frequently.

25. This conference is of opinion that the constitution of the Madras Medical Council is contrary to the spirit of modern times and so recommends to the Government and the Legislative Council to take up the matter to so change it as to abolish the present system of election of representatives in water-tight compartments and of nomination so as to obtain a majority of elected representatives and in the council and to provide for an elected President.

26. This conference requests the Government to establish the proposed Central Medical Research Institute at Vizagapatam, in view of its being the headquarters of the Andhra University, its possessing a well-equipped hospital, its growing importance due to the harbour and its bracing climate.

27. This conference congratulates Dr. T. S. Titumurti as he was the first man to hold the office of the Vice-Chancellor of the Andhra University among the members of our profession.

28. This conference authorises the Secretary of the Tanuku Medical Association to communicate these Resolutions to the authorities and persons concerned and to the Medical Journals and the press.

Some Irregular Fevers in Madras *

By T. Satakopan, M.D.,

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I have taken for to-night's talk the very big subject of irregular fevers in Madras. Indeed it is impossible to compare this vast subject within an hour's talk, and I do not by any means presume to exhibit a thorough survey of this field. In choosing this subject my object has been merely to state a few types of cases of fever which have not as yet been satisfactorily labelled. These fevers can be broadly classified into two groups.

1. Fevers which generally present a constant picture of temperature chart, but which occasionally show an irregular temperature curve.

2. Fevers which from onset to convalescence behave quite irregularly in their temperature reaction.

In the first group, *i e.*, fevers which generally have a constant temperature reaction, but which sometimes behave irregularly, those that come to our mind are Malaria—the various types of it, the enteric group of fevers, pneumonia, dengue and the various exanthemata.

Malaria.—It is notorious how often one fails to diagnose a case of malignant tertian malaria as such, merely because of the apparent or real absence of intermittency in the temperature of the patient. While the periodicity of the pyrexia is constant and characteristic in cases of benign tertian and quartan infections, in a very large number of cases of malignant tertian infection one vainly endeavours to see a similar picture. It is commonly the

* Read at a clinical meeting of the South Indian Medical Union.

case that if one desires to study the temperature range of a fever case, one generally depends on a fourth-hourly record. But I have often seen that when one could not make out any alternating periodicity from the fourth-hourly chart, one could see awell marked effort at such alternating periodicity from an ordinary morning and evening temperature chart. May be, that one finds a complete intermission, or only a remission, but the peaks are only noticed on the alternate days. There are a number of cases in which there is no evidence whatsoever of even the least approach to periodicity, the temperature chart merely showing a remittent picture. Even in these cases, if one carefully scrutinises the temperature chart one may still discover some signs of alternating periodicity in the first few days. It is only later that the temperature and the paroxysms are completely irregular. Some of the common mistakes committed in the diagnosis of malignant malaria are as follows: (*a*) cases neglected in the early days, when first seen with a constant temperature of 103° to 104° are sometimes mistaken for typhoid fever, (*b*) cases with nasal or nasopharyngeal catarrh and high temperature are on account of the presence of a few rales and slight delirium occasionally diagnosed as pneumonias, (*c*) chronic cases with occasional rises of temperature and slight rigors together with the run-down state of the patient may be mistaken for tuberculosis of the lungs. On the other hand, most cases of filarial fever are in the first instance diagnosed as malaria before the true nature of the illness is suspected.

Enteric fevers.—Of the enteric group of fevers, that produced by the infection of B. typhosus is known for its classical temperature curve, the early step-ladder rise, the second week of table temperature, and the final remittent descent to convalescence. But it must have been the experience of most of us to see a case of typhoid fever for the first time in the third week. And when as it happens, the history of the early stages is not intelligent, one is at a loss to diagnose these cases in the absence of any of the various complications incidental to this fever. One generally depends for the diagnosis on the laboratory results of Widal test.

But the other fevers of this group due to the paratyphoid organisms are often characterised by a very irregular temperature reaction. Besides, these fevers are much milder in their constitutional effects, rarely manifesting any of those symptoms which are characteristically associated with typhoid fevers. Under these circumstances, diagnosis is really a matter of some difficulty. But correct diagnosis is very essential in these cases, since paratyphoid infection, though generally mild in its manifestations is still liable to be attended with all the serious and often fatal complications of haemorrage and perforation.

It is therefore necessary very early to do the Marris' Atropine test, do a blood culture and after a week examine the blood for Widal reaction. But apart from these elaborate and highly technical methods, the character and rate of the pulse often help the physician a good deal. I have recently come to rely very much on the presence of the slow, low tensioned and dicrotic pulse as a great indicator of enteric infections. Doubtless there are certainly other fevers which show a slow pulse. These I shall come to presently.

Kala-Azar is another very common fever in which the temperature, though irregular, is still very distinctive. In its onset, this fever may closely resemble some of the other well known fevers, or it may resemble none. At the start, it may closely resemble typhoid fever. I am sure, it has been

the experience of most of us, in our inexperienced early days to have clinically diagnosed cases as typhoid fever, and when the bacteriologist reports 'Widal negative', with an incredulous smile waive the report aside as incorrect or ascribe the result to the bacteriologist's carelessness or to one of many such fallacies. Remembering also Osler's advice, that when the clinical symptoms point strongly towards typhoid fever if the Widal reaction is negative to ignore the laboratory and be guided by the clinical signs, we are more than ever convinced that we are right and the bacteriologist is wrong.

Now, what is the picture of a case of kala-azar at its inception? It is very often somewhat as follows. You are called in to see a patient with fever—rise of temperature—you learn that the patient has been having some fever for the past few days. He did not think much of it. He was going about his work as usual but finding that the temperature was rising, the patient has sent for you and when you see him he has a temperture of 103° and 104° F.

This temperature is maintained for the next few days or weeks. The patient is a little dull. His abdomen is slightly tumid, spleen is just palpable, but grows larger while under your care. The blood is examined and the findings are somewhat as follows-no malarial parasites, slight secondary anaemia and leucopenia. As the thoughts are centred round typhoid fever, blood is sent for Widal reaction. A few days later the report is "negative." You hesitate. By the time diagnosis is decided, the temperature is probably getting lower and in a few days reaches normal. Often the picture is considered complete for typhoid fever. The patient is taken to be convalescent. The patient feels keenly hungry, his diet is made more generous. He is permitted to sit up. That very day or the day after, it chances that his temperature goes up. You feel that you have permitted the patient to sit up a little too early. He is promptly put back to bed and not permitted to sit up. But the temperature does not return to normal. It keeps up or mounts higher. The spleen is getting bigger. It is a pity! You exclaim that there is a relapse of typhoid fever. The patient is watched, drugged and dieted for typhoid fever, absolutely ignoring his pathetic appeals for more food. After a week or two the temperature drops to the red line. There is a sign of relief. The patient and his people get many warnings and admonitions as to longer rest in bed and more restricted diet. But all this caution does not avail. There is a return of pyrexia. But blind to the slight sallow skin of the patient, his brittle falling hair, clean tongue and the very keen appetite, typhoid fever is still heed on to—for has not one read of four and five relapses in typhoid fever—until one day a shadow flits across the physician's mind that he has been persevering on the wrong road. Are there any signposts along the route, attention to which might have obviated this getting into the woods? Yes. A careful examination of the pulse every day in the early stages of the fever, the presence of lymphocytosis or mononucleosis in the blood, culture of blood for enteric organisms in the early days of the illness, the routine employment of Marris' Atropine test in the first and second weeks of fever, the condition of the tongue and above all the steady enlargement of the spleen and the repeated examination of the blood for Widal reaction noting the presence or absence of a rising titre. These points if attended to will, in the vast majority of cases, direct us to a correct diagnosis.

There are a number of other conditions in which one comes across an irregular temperature reaction, *e.g.*

cerebro-spinal fever, acute anterior poliomyelitis, visceral syphilis, tuberculous infections, malignant endocarditis, etc. It is not possible to treat of these conditions in a short paper as this. But I should like to mention a few words on some conditions which are generally likely to be overlooked. Of these, I shall just refer to pleurisy, B. coli infections and tropical liver abscess.

Pleurisy.—One would think that with the physical signs characteristic of this condition, there cannot be much difficulty in diagnosing it when it causes an irregular pyrexia. The pleuritic rub is the characteristic sign. The sound varies with the degree of friction. In acute cases the sound may be strictly localized and easily missed, as Poulton says, it may be even absent in some cases, that is, if the patient is prevented by the severe pain from making the inspiratory movement necessary to produce it. Again in the early stage of interlobar pleurisy, there may be pain, cough and oppression of breathing, but no distinctive sign. Also in diaphragmatic pleurisy, dullness, friction sound and oegophony are absent unless the trouble reaches the main pleural cavity and thus a small collection of liquid encysted here which may be easily overlooked. Likewise a mediastinal pleurisy may show few distinctive signs unless the collection of fluid is large enough to press upon the structures in the middle line of the chest. Hence, in all but acute cases, the pitfalls are so numerous in diagnosis that an early exploration with needle and syringe is essential. And as this is the only way of determining the nature of the fluid, whether serous or purulent, there should be no reluctance to make use of this procedure.

Liver abscess.—A careful enquiry into the anamnesis, nature of onset and course, the passing in review of the symptoms, the determination of the presence of marked leucocytosis in blood with an exploration with needle and syringe in several places of the region of the liver will help diagnosis in most cases.

B. coli infection.—Infection of the genito-urinary tract has only to be remembered to be correctly diagnosed and treated.

This paper is not an exhaustive treatise on the etiology of irregular fevers. But still one cannot avoid mentioning the subject of cryptic focal sepsis. In recent years, hidden focal sepsis has acquired a vast amount of importance as a possible cause of morbidity. It is only necessary to instance the case of pyorrhœa alveolaris conditions ranging from vague ill-health to hyperpiesis and chronic interstitial nephritis, from mild indigestion to incurable anaemias ; all these have been held to be ultimately due to this very common disorder of the teeth. The energy and enthusiasm with which people have been rendered toothless is evidence of this mentality. Without subscribing to this apparently absurd theory, the importance of a rapid and thorough examination of the patient, going over from system to system, part by part of the whole body cannot be over emphasised as a preliminary to the diagnosis and treatment of irregular fever. How often has not an attending physician groped in the dark treating a case of fever day after day, week after week till some one detects to his great discomfiture, the presence of a perineal or ischio-rectal abscess, uterine sapræmia or tonsilar sepsis ?

As an instance of quite unexpected causes of prolonged irregular pyrexia, I shall quote the case of a patient who was admitted into my wards. He was a young man of twenty-five years. He gave a history of pyrexia of four months duration. He presented a sallow skin, spleen enlarged to one inch below

the umbilicus, liver three inches below costal margin and a remittent temperature between 101° and 103° to 104° F. Kala-azar was suspected. Blood was sent for signs of leucopenia. No parasites were found in the liver puncture smears. The pathologist reported the presence of well marked signs of pernicious anaemia. Subsequently it was found that the patient had definite signs of subacute combined degeneration. The patient improved rapidly on the appropriate treatment for the pernicious type of anaemia, but when the patient left the hospital, he was not quite cured though the temperature was controlled.

Irregular fever caused by complications.—It is not unusual to find that some of the fevers with a typical temperature reaction, exhibit irregularity in their temperature curve. Some of the more common of these is the association of malaria with kala-azar, with tuberculosis of the lungs, and typhoid fever. Generally in the beginning, the blood examination shows malarial parasites. The patient is put on quinine. But in spite of sufficient quinine the temperature instead of coming down to normal, still keeps up and runs an irregular course. The mistake is, to think that quinine has not been absorbed and to persist in quinine drugging. The wiser course would be to seek for the cause elsewhere, if the temperature has not been controlled after a definite quantity of quinine has been administered.

Unlabelled Fevers.—In spite of the great strides made in the elucidation of obscure conditions and in spite of the intensive research that is being carried on in the diagnosis and treatment of several diseases obtaining in the tropics, the number of pyrexial conditions of unknown etiology is still almost a legion. Since Rogers began writing about fevers, medical men in this country have been content to diagnose fevers of short duration by the number of days of illness. It is not very edifying to call a fever 'seven days' fever, five days or three days fever,' particularly when one is not sure that all these fevers may not be of the same cause.

In Madras, we have recently been getting patients with fever of one to seven or eight days' duration. Most of them do not show any other symptoms, while a few complain of slight headache and a little aching of the limbs and back. Some have a mild nasopharyngeal catarrh. One of my patients complained of retention of urine and difficult micturition. No malarial parasites were seen in the blood smears. Leucocytes do not show any definite changes. There is no leucocytosis. The only distinctive feature of these cases is the slow pulse relative to the temperature. The occurrence of a few cases with nasopharyngeal catarrh and the pain in the body makes one think of influenza. Some authors have noted a definite slow pulse in influenza, the slowness persisting even in convalescence, thereby differing from the slow-pulsed enteric fevers which present this feature only in the early stages. But in the series of cases here referred, there was no leucocytosis which is generally said to be a feature of influenza. In the absence of any unanimity about any particular organism being the cause of influenza, we are not in a position to say whether the present series of cases is influenzal or not. Again one may suspect these cases to be of dengue fever. Except the slow pulse, there is nothing in the character and course of these fevers to suggest the latter cause. We can only say that in Madras there is prevalent just now a type of fever of short duration characterised by a relative slow pulse and mild constitutional symptoms without any associated rash. The whole illness is so short and mild

that patients get well without any special treatment.

Finally I desire to invite your attention to a few cases of fever which have been met with in Madras. The fever is in almost all respects a case of enteric fever. Blood is positive for Widal 1 in 200 for B. typhosus, and for para-typhoids positive or negative indifferently. The fever seems to run the usual course without any serious complications. After a time, the temperature comes to normal and keeps normal for a few days. The patient feels better and has a good appetite. There is then a gradual rise of temperature which is irregular in course and prolonged. Except for the pyrexia the patient does not feel ill. All this time, there is very slight or no enlargement of the spleen. There is a slight leucopenia. Liver puncture smears do not show any *Leishmania* donovani. But when the patient is put on ureastibamine the temperature drops to normal and the patient gets well. This would suggest that in addition to kala-azar and septic fevers, there are other fevers which are also controlled by ureastibamine or similar pentavalent compounds of antimony.

Adenoids and Tonsils—Their baneful effects*

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The word "Tonsils" when not qualified by any word generally means the two lymphoid masses on either side of the tongue. But there are other tonsils also. Hence to distinguish these, various names are given to them according to their situation. The two tonsils situated on either side of the tongue are known as *faucial* tonsils. There is a small tonsil in the naso-pharynx called *pharyngeal* tonsil (commonly known as Adenoids, when enlarged) and there is another tonsil in front of Epiglottis at the base of the tongue known as lingual tonsil. The soft palate as it stretches out towards each side of the throat becomes divided into folds front and back called respectively the anterior and posterior pillars. Between these folds or pillars lie the two faucial tonsils. These structures when normal are small, almond shaped bodies about an inch in length and half an inch in width and thickness. Normally they do not project beyond the two folds between which they are situated but they are very frequently enlarged from repeated attacks of inflammation, when they may reach such size as to come into contact with one another almost closing the throat.

The pharyngeal tonsil (or the tonsil of Luschka) is situated in the nasopharynx or post-nasal space which is the upper part of the throat lying just back of the nasal passages and its lower limit marked by the arched soft palate. This tonsil is normally present, in young children but often abnormally enlarged, then constituting the growth known by the name of "Adenoids". Naturally this, situated as it is at the upper part of pharynx and concealed by the soft palate, can't be seen with naked eye but can be visible with the posterior Rhinoscopic mirror and in children where it is not possible to use the mirror, examination with finger will give a clear idea of its size and situation. There is still another tonsil in the throat of which we do not hear much. This is the lingual tonsil at the base of the tongue in front of Epiglottis. This may give rise when inflamed to very annoying symptoms. This is of special interest to singers and

* Read before the South Indian Medical Union, Madras.

others who use the voice habitually, since when enlarged it may give rise to hoarseness and other voice symptoms. Very little is known of the function of tonsils but the one most generally ascribed is that of protecting the organism by way of phagocytosis.

The word " Tonsil " wherever it occurs in this paper when unqualified means faucial tonsils and adenoids will be used for the enlarged pharyngeal tonsil.

Adenoids.—Some factors as dampness, bad air and insanitary surrounding are admitted as having an influence on adenoid growth. But they are too general to be regarded as definite causes. Another theory is that the ingestion of excess of sugar is responsible, while another theory attributes it to the infantile habit of thumb sucking. Heredity is believed to have strong influence from the frequent occurrence of the disease in several members of the family.

In so many and devious ways can adenoids produce their ill effects upon the human system, that there is scarcely any part of the body that can escape surely and no organ that will be wholly exempt. As you already know, the existence of adenoids is fraught with the most serious consequences to the health of the individual pointing eventually to the deterioration of the race. It stunts the growth and development of the child renders him a prey to every passing illness. It disorders his functions, robs him of his vitality, paralyses his faculties and generally impairs the physical, mental and even moral status of the unfortunate child that happens to be subject. Adenoid is the enlargement of lymphoid tissue in post-nasal space and is quite analogous with the structure of tonsils. There are a number of little pits or blind alleys opening on the surface of this structure. These openings are filled with decayed substance. When this structure is once inflamed it becomes the breeding place for germs. Here they multiply rapidly and carry on their nefarious activities without hindrance. This lymphoid tissue when enlarged and diseased constitutes a most vulnerable point of attack for hostile organisms. These micro-organisms, in course of time, overrun their boundaries and spread the infection to neighbouring structures. Their extension to nose is followed by acute coryza and extension to pneumatic spaces is followed by sinusitis. When it spreads to faucial tonsil it results in pharyngitis, to laryn, in laryngitis and to bronchi, in bronchitis.

The situation of adenoid growths and their proximity to important organs explains many of the ill effects of their presence.

Effects on nose affections.—First situated as they are close to the nasal passages they block the passages and invalidate all the highly important physiological process of the nasal respiration. The child is forced to breathe through the mouth and thus the constant entrance of unfiltered air into the throat makes the throat parched and dry and leads eventually to a catarrhal state of the entire lower respiratory tract. Due to the unhealthy state of the mucous membrane the lungs function imperfectly, the blood is insufficiently oxgenated and general anæmia ensues. Impoverished blood circulation through the system explains the general debility and malnutrition which these little patients usually exhibit. Extension of the disease to the nasal mucous membrane causes frequent colds and in fact the child with adenoids seem to be never free of cold, one attack following on the other so closely thus causing what is called the " state of snuffles ". Further extension of this infection to the pneumatic spaces produces sinusitis.

In fact colds are so closely connected with ·adenoids that this is regarded by physicians as one of the most convincing symptom of adenoids.

Effects on ear.—As the eustachian orifices are so close to adenoids their enlargement is bound to encroach on these orifices by partially, if not completely, blocking the orifices and thus the natural entrance of air to middle ear. In any event interference with the respiratory current is enough to cause aural complications because the normal supply of air to the middle ear from the nasopharynx through the eustachian tube is cut off. Under these circumstances the structures of the ear must suffer. The eustachian tubes are the ventilating shafts passing from ear to throat. Any obstructions to these is a serious menace to sense of hearing. If obstruction is not removed permanent impairment of hearing might result. When the adenoid infection passes up the eustachian tubes it can produce an abscess in middle ear with its consequent evils and dangers. It is an established fact that a large percentage of deafness of adults has its origin in adenoids which were not removed during childhood. Earache is a very common symptom and this, in a child, should always arouse the suspicion of adenoids. In many cases the aural trouble progresses to the stage of chronic persistent discharge from ear which can never be completely got rid of without removal of adenoids. A chronic middle ear suppuration in a child is almost a sure sign of adenoids excluding tuberculosis.

Mouth breathing with its effects—Adenoid vegetations by obstructing the nasal passage make the child a mouth breather. This brings me to say something about the nasal obstruction and the consequent breathing by mouth and its evil effects. Nature has constructed the nose with its peculiar turbinates and mucous membranes, chiefly to prepare the inspired air by warming, moistening, filtering and purifying it so that it shall be fit to enter the sacred precincts of lungs. When the current of air has to take to other than nature-provided routes due to obstruction at the nose, it is deprived of the preparatory process because the membranes of the mouth are not fit to perform the same duties. It is as much physiological to practise eating through the nose as it is to breathing through the mouth. When the inspired air is deprived of the benefit of nasal functions it enters the lungs in such impure and unfit condition that the process of oxygenation of the blood is very imperfectly performed. This accounts for the anaemia and malnutrition prevalent among mouth breathers. The whole respiratory tract below the nose suffers in consequence of the mouth breathing. The air attempting to get the moisture from the mucosa of the mouth works havoc on them making them dry, glazed and parched and the constant deposit of dust and irritant substances is certain to give rise to catarrhal inflammations, of pharynx, tonsils, larynx, trachea and bronchial tubes. These parts become less resistant and the lungs naturally are more likely to become a prey to tuberculosis.

Propagating infection.—Adenoids are causing more havoc by propagating infections. Microscopical examination of these specimens show them filled with bacteria, and being easily inflammable structures, it is natural that germs should be incited often to increased activity quickly spreading to other parts. Thus travelling through eustachian tube they give rise to middle ear suppuration. Absorbed into lymphatics they produce enlargement of the glands of the neck and under-jaw which are often found to be of tuberculous nature. Toxaemia and acute general infections are believed to have their origin in adenoids. At any rate there is no doubt that a child with adenoids by reason of the lowered vitality

becomes more easily a prey to infectious fevers peculiar to childhood.

Children with adenoids are likely to be anaemic, ill nourished and under-developed and since they have invariably enlarged glands in the neck, the tendency is to give them the appearance of Scrofulosis.

Effect on nervous system.—That the adenoids have a profound effect on general nervous system is beyond doubt. But a few authors have gone even to the extent of saying that the derangement of mental faculties leads in many cases to insanity. It is very evident when we consider the anatomical conditions of the situation of adenoids on the roof of the nasopharynx in the proximity of cribriform plate of ethmoid, a thin paper bone which is both the roof of the nose and floor for the brain substance. In many cases the mental faculties can be seen much affected and the child not only looks stupid but is actually in a state of mental lethargy. These children are conspicuous by their lack of memory and inability to concentrate the attention. They show evidence of nervous irritability. They are fretful, peevish excitable or morose. Chorea may have its cause in adenoids and so also nervous cough and spasms of the throat and asthma.

Adenoid picture.—A child with adenoids presents invariably the following picture. The nose is more or less stopped. There is almost constant running from the nose. Sometimes bleeding from nose. The catarrhal symptoms are sometimes worse at night and attacks of croup may develop. The mouth is kept open during sleep and the breathing is noisy or there may be loud snoring. At night they might have night-terrors, spasms of the glottis and nocturnal enuresis. Every time an attack of cold occurs the symptoms are aggravated and thick yellow discharge from nose or in the throat is seen. This discharge from the throat when swallowed produces digestive disturbances. The voice of an adenoid child tends to betray him. The voice is lacking in resonance, being "woody" in effect and the articulation is imperfect due to impeded movements of the palate. Hoarseness, loss of voice and spasm of glottis are a few of the serious vocal symptoms. A few skeletal malformations are observed due to mechanical effects of obstructed breathing at a time of life when the walls of the chest are flexible. What is called "pigeon breast" deformity is very common. The facial expression or configuration is very typically modified by the presence of adenoids and in its typical form is very characteristic. The nose is narrow and pinched, upper lip is generally short, swollen and often excoriated from constant nasal discharge. The mouth is nearly always open so that the upper teeth are exposed to view. These are seen to be irregular, projecting and discoloured. The eyes are usually lustreless and the general effect is to give a dull, stupid and vacant expression.

Tonsils.—Diseased faucial tonsils are in no way less injurious than adenoids. Being of the same structure as adenoids they are naturally influenced by the same causes and as a matter of fact enlarged tonsils and adenoids are found invariably together. The tendency of adenoids towards mouth breathing naturally irritates the mucous membrane of the mouth and thus exaggerates the natural tendency to hypertrophy of tonsils. The tonsils are liable to frequent attacks of inflammations known as Follicular Tonsilitis characterised by filling up of the crypts with diseased exudate, later developing into abscesses in the substance of tonsil. Later this infection may spread into peritonsilar connective tissue thus producing the condition known as "Peritonsilar" abscess (quinsy) marked

by intense agony, painful swallowing and systemic disturbances as well as local distress. Due to repeated attacks of inflammations the tonsils form adhesions to the neighbouring parts and sometimes the neighbouring parts overgrow while the tonsils shrink. This looks to a casual observer as a harmless tonsil but in fact it is the worst of its kind being a veritable cesspool for blood stream infection. Due to the frequent pus pockets and accumulation of pus and the consequent toxic infection of various parts and organs of the body the tonsils give rise to more serious systemic disturbance than do adenoids. The most common ailment is Rheumatism. It seems that the toxin prepared by the tonsils has a special affinity for the serous linings of the joints, so that the so called arthritic pains in any part of the body give good reason to suspect the tonsil as the seat of infection. Although tonsil infection may effect any part, the most commonly affected parts are muscles of the neck and shoulders, a soreness and stiffness of the muscles of this region being quite characteristic. Even the serous linings of the heart do not seem to escape this infection, the more serious affections being pericarditis and endocarditis, any of which may endanger one's life.

Kidney inflammations, high blood pressure and general ill-health are also very frequent occurrences. It is to be borne in mind that enlarged lymphatic glands in the neck are not always tubercular but in many cases the tonsils are the original seat of the glandular trouble and after their removal the swelling in the neck may subside. The most prevalent popular belief that a child will outgrow adenoids and tonsils is a great fallacy. Unfortunately it is being lent support, in some cases, by the family physician when he happens to have little experience. This belief has its origin in the fact that adenoids tend to harden and shrink at the age of 12 to 14 years, which although may happen in some is not always the case. This belief added to the natural dread of parents to allow their children to be operated upon raises a hope in many to try if an operation can be avoided. But the inexperienced doctor as well as the parent are overlooking a very important factor in their eagerness to avoid operation. By the time the tonsils or adenoids begin to shrink at the age of 12, they would have completed their mischief by frequent inflammations, etc., and would have left behind intractable and permanent evils, which it is impossible in later years, with the most painstaking care and with the cleverest medical attention, wholly to remedy. For the faucial contour has become permanently altered, the teeth are distorted and diseased beyond complete repair, a chronic suppuration is present in middle ear, the throat and respiratory tract are so weakened that colds are contracted upon the slightest provocation and the unfortunate subject's lungs are so weakened that perhaps he had become the victim of tuberculosis. Adenoids may shrink after doing all this mischief but tonsils may still go merrily on with repeated inflammations and infections. However important the functions of an organ may be when healthy and however capable they be of performing these functions once they are diseased they become not only incapable of performing their healthful functions but they are also disturbing in many ways the functions of the other organs and giving rise to far-reaching systemic disorders of the most serious nature. Is it not then our duty to get rid of that organ? Indications for operations, how to decide whether tonsils are diseased or not, the various operative procedures and the choice of operation with its details will be dealt with later in another paper.

It is most deplorable that in our country no steps are taken to educate the public about the harmful effects of adenoids and tonsils. It is shocking to note the ignorance among the public of the evil effects of these structures. Once the public are educated about their evils, the benefits of their removal and when they are impressed that the operation is absolutely without danger I am sure the parents will shake off their fear of operation and will be coming forward more eagerly to get their children operated upon at an early age before irreparable mischief is done. I hope it is hardly necessary for me to mention that this is the case in many European countries especially in Vienna and Italy. There regular propaganda work is done by articles in newspapers and magazines, magic lanterns, lectures, putting up educative illustrations in the out-patients of the various hospitals with descriptive pamphlets and appointing specialists as medical inspectors for schools and factories to examine the children periodically and impress on the parents about their baneful effects. With such ingenious propaganda there is nothing to be surprised if every mother in Vienna diagnoses the disease in her child and of her own accord brings the child to the hospital to be operated upon. But unfortunately in India every one seems to be asleep regarding this. Steps are taken to irradicate malaria and to fight tuberculosis but alas no steps are taking to attack the root cause of all this. Take care of the plant and the tree will take care of itself. Protect the health of the child and build up a strong healthy child; then tuberculosis and other infectious diseases will take care of themselves. Once you neglect the child and allow it to grow up a constitution suitable enough for the diseased germs to grow and multiply, any amount of our present struggle to fight these diseases is bound to fail and the result ultimately is bound to end in our becoming a nation of stunted growths and unhealthy constitutions which are fertile soils for infective diseases with consequent deterioration of the race. Hence it is time that responsible authorities take up this task of educating the people and eradicating the evil in its infancy and save our country from physical and consequent mental insolvency. They can insist on schools, colleges and factories appointing specialists for periodical examination of the children and in cases where operation is advised they should make arrangements for cheap medical aid to the people. They can send enthusiastic young doctors to foreign countries (I specially recommend Vienna) for special study of the subject and the methods adopted in those countries to eradicate the evil and on their return they should avail of their foreign experience and study. When I mention that 60 to 70 per cent of the school-going children in European countries, where systematic examination by specialists are a routine, are found to have adenoids and tonsils and consequently advised operation it is hardly necessary for me to impress on you that India is more in need of some steps to be taken to fight the numerous but easily vanquishable foe. Here is a big field for philanthrophic men who are toiling for the welfare of the children and if they take up the task with the aid of experienced medical men and specialists I am sure they will be successful in removing the chief obstacle to a child's healthy and potent growth.

I thank you gentlemen for your patient hearing and I close this paper. Once again emphasising on the duty of the profession, of impressing on the public about the evils of Adenoids and Tonsils and thus discharging one of the many obligations that the medical profession owes to the lay public.